Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Vandetanib

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579**. If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: ________________________ **Date**: ________________________
Patient's ID: ________________________ **Patient's Date of Birth:** ________________
Physician's Name: ________________________
Specialty: ________________________ **NPI#:** ________________________
Physician Office Telephone: ________________ **Physician Office Fax:** ________________
Physician Office Address: ____

1. What drug is being prescribed? ❑ Vandetanib ❑ Other _________________
2. What is the diagnosis?
   ❑ Medullary thyroid cancer
   ❑ Other ______________________________
3. **What is the ICD9? ______________**
4. Is the thyroid cancer symptomatic or progressive? ❑ Yes ❑ No
5. Prior to initiating therapy, did the patient have unresectable locally advanced or metastatic disease?
   ❑ Yes ❑ No
6. Does the patient have hypocalcemia, hypokalemia, or hypomagnesemia?
   ❑ Yes ❑ No **If no skip to #8*
7. Will the hypocalcemia, hypokalemia, or hypomagnesemia be corrected prior to vandetanib administration? ❑ Yes ❑ No
8. Does the patient have long QT syndrome? ❑ Yes ❑ No
9. Will the ECG be monitored according to recommendations provided in the prescribing information for vandetanib? ❑ Yes ❑ No
10. Is the patient receiving any drugs known to prolong the QT interval?
    ❑ Yes ❑ No **If no, skip to #12*
    Including, but not limited to: amiodarone, disopyramide, procainamide, sotalol, dofetilide, chloroquine, clarithromycin, dolasetron, granisetron, haloperidol, methadone, moxifloxacin, and pimozide
11. Will the ECG be monitored more frequently than recommended for patients not receiving QT-prolonging drugs? ❑ Yes ❑ No

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Patient Name: ______________________________ **Patients Date of Birth:** ________________________
Patients ID : ______________________________

12. Is the patient currently receiving vandetanib? ❑ Yes ❑ No **If no, no further questions*
13. Is the patient continuing to benefit from vandetanib therapy? ❑ Yes ❑ No

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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